DEPARTMENT OF THE ARMY
MADIGAN ARMY MEDICAL CENTER
Tacoma, Washington 98431-1100

MAMC Regulation
Number 40-60

13 May 1999

Medical Services
MADIGAN PROVIDER HEALTH PROGRAM (MPHP)

1. Purpose. This regulation establishes policy, responsibility and procedures at Madigan Army Medical Center (MAMC) for the impaired Health Care Providers (HCP). This program is mandated by AR 40-68 and provides the mechanism for identification, management, reporting, advocacy and prevention of impairment.

2. References.

a. AR 40-68, Quality Assurance Administration.

b. AR 600-85, Alcohol and Drug Abuse Prevention and Control Program.

c. AR 614-5, Stabilization of Tours.

d. FL Regulation 690-15, Fort Lewis Employee Assistance Program and Civilian Counseling Service.

3. Explanation of Abbreviations and Terms. Abbreviations and special terms used in this regulation are explained in the Glossary.

4. Responsibilities.

a. Chair, Madigan Provider Health Program (MPHP) Committee.

(1) Recommends to the Commander, MAMC management of individuals identified as impaired.

(2) Recommends procedures for the management of impaired HCPs.

(3) Evaluates individuals referred to the MPHP for evidence of impairment.

(4) Makes recommendations regarding the restrictions/monitoring of clinical practice for impaired HCPs.

(5) Monitors the rehabilitation of impaired HCPs during treatment, aftercare/follow-up care and monitoring periods.

(6) Makes recommendations regarding the phased return to full clinical practice after treatment or identification (monitoring plan).

(7) Develops and provides educational programs for the institution on recognition, responsibilities and procedures regarding the impaired HCP and the role of the MPHP Committee.

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*This regulation supersedes MAMC Regulation 40-60, 10 Jun 96

(8) Reports impaired HCPs via DD Form 2499 (Health Care Provider Action Report) through established channels when regulations demand.

(9) Communicates with supervisors and chiefs. The Committee will notify supervisors of their responsibilities when they have an impaired HCP.

(10) Communicates with impaired HCPs.

b. The Center Judge Advocate General (JAG) or Medical JAG Officer provides guidance by consultation, prior to confrontation, on possible criminal violations, recommends related procedures and serves as an ad hoc member of the committee as needed.

c. Medical Company Commanders initiate any investigations of possible criminal conduct. They also make the referral to ADAPCP.

d. MAMC staff cooperate with the MPHP Program in accordance with AR 40-68 and this regulation.

5. Policies and Procedures.

a. MPHP Committee Membership.

(1) The membership will include the following:

(a) Chair (appointed by the Deputy Commander for Clinical Services (DCCS)).

(b) Medical Clinician (minimum of one).

(c) Psychiatrist.

(d) Registered Nurse (appointed by the Chief Nurse).

(e) Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) representative.

(f) Chief, Quality Services Division (QSD).

(g) Troop Commander/Chief, Military Personnel.

(h) Senior Enlisted Representative.

(i) Credentials Coordinator (recorder).

(2) Some members may have multiple status. One member must be a successfully recovered HCP (see AR 40-68, Chapter 7). One member shall be a residency program director. One member will serve as the education coordinator.

(3) Members will be nominated by the MPHP Committee and approved by the DCCS.

(4) Consultants to the MPHP Committee include:

(a) Chief, Graduate Medical Education (GME).

(b) DCCS.

(c) Center JAG.

(d) Civilian Personnel Advisory Center (CPAC), Employee Management Branch.

b. Psychiatric or Medical Impairment Management.

(1) Any HCP known or suspected of having a medical or psychiatric problem which impairs (or could potentially impair) their ability to perform safely, will be reported to the MPHP either verbally or in writing. The MPHP will request the following:

(a) A statement of diagnosis, prognosis and implications for clinical performance from the primary clinician treating the impaired provider, when one is identified.

(b) A statement concerning current clinical performance from at least one immediate supervisor.

(c) Recommendations from the department/service chief regarding the HCPs scope of clinical practice.

(d) Input from the individual, when appropriate.

(2) The MPHP will review the statement and recommendations and recommend limitations of practice, when required. For privileged HCPs, those recommendations will be made to the Credentials Committee for their action, then to the Commander for approval. For categorically privileged HCPs, the recommendations will be made directly to the department chief and/or DCCS, as appropriate. For providers in GME training, the recommendations will be made to the Education Committee with communication to the residency director.

(3) The MPHP will serve as an advocate for the HCP and liaison to the system to protect the HCP and the system, to preserve confidentiality, to expedite evaluation and/or treatment and to promote fair and equitable treatment of all HCPs within system boundaries.

(4) Reports.

(a) HCPs will be notified by the MPHP when they are being officially followed and of the role of the MPHP. The HCP will be asked to sign an acknowledgement of this action.

(b) The supervisor of the monitored impaired HCP will submit written reports to the MPHP according to the predetermined contract between the impaired HCP, the supervisor and the MPHP, regarding duty competence during the monitoring period. The supervisor will provide feedback on these evaluations with the HCP.

(c) Individuals monitoring impaired HCPs will notify the supervisor and the MPHP immediately upon any sign of relapse or failure to follow the monitoring plan.

(d) Monthly written progress reports will be submitted to the Credentials Committee on any individually privileged impaired HCP who is being followed by the MPHP.

(e) Monthly written progress reports will be submitted to the Education Committee on any impaired HCP in GME being followed by the MPHP.

(f) Reports will be provided to the commander on a regular basis through the MPHP Committee minutes. The commander (or his representative, usually the DCCS) will be notified when an impaired provider has been officially added to the MPHP log. Confidentiality will be maintained through use of confidential cover sheets.

(g) QSD, Credentials Management will prepare all DD Forms 2499 on impaired HCPs. The DCCS Will approve and sign all DD Forms 2499 prior to submission to higher command. QSD, Credentials Management will maintain the institutional record for all MPHP documentation with the exception of Troop Command records on enlisted personnel.

c. Alcohol or Drug Abuse/Dependence/Impairment Management.

(1) Case Finding. All active duty HCPs are required by AR 40-68 to report HCPs whose clinical practice is impaired or potentially impaired. The MPHP will ensure that the department chief is informed and will serve as a resource to the department chief for recommendation on monitoring or employment of confrontation.

(a) Monitoring will be used only when there is no clear evidence with which to confront the HCP. The department chief will send a memorandum for record (MFR) to the MPHP describing the circumstances and specifying the type of monitoring that will be conducted.

(b) If there is any evidence of job impairment, the supervisor will objectively confront the HCP with evidence of impairment (see para 5c(1)(c) below). The supervisor may request a representative of MPHP to be in attendance during this session.

1. Active duty, Reserve, and National Guard HCPs will be referred to ADAPCP for full evaluation. For active duty personnel, this will be accomplished through close coordination within the individual's company commander.

2. The supervisor of civil service HCPs will contact the CPAC, Employee Relations Branch for advice prior to confrontation.

3. The supervisor of contract HCPs will contact the Contracting Officer's Representative whenever there is a concern about the conduct or performance of a contract employee.

(c) The supervisor will provide an MFR to the MPHP describing the evidence and future expectations as given to the HCP, with the HCP's

response. The supervisor will document DA Form 3881 (Rights Warning Procedure/Waiver) that the HCP has been advised of his Article 31 Uniformed Code of Military Justice (UCMJ) rights. The HCP will not, under any circumstances, be questioned about the impairment without the appropriate guidance from the JAG office and preparation and signing of the DA Form 3881. For active duty personnel, if the potential exists for identifying criminal misconduct, coordinate the action with the individual's company commander and the JAG.

(2) Intervention. Intervention will be used when the behavior that impairs or potentially impairs clinical performance is clearly related to alcohol or other drug abuse or dependence. The HCP will be removed from direct patient contact until the MPHP Committee determines that the problem is satisfactorily controlled. Impaired HCPs requiring inpatient treatment will have their clinical practice re-evaluated upon return to the duty station.

(3) Coordination of Treatment. If treatment is appropriate, there are multiple options that may be utilized. Treatment will be coordinated through the ADAPCP for active duty or civilian personnel under the provisions of AR 600-85. The individual's company commander will coordinate ADAPCP enrollment and monitoring.

(4) Aftercare/Follow-up Care. If outpatient treatment (Track I or Track II) is utilized, the MPHP Committee will monitor follow-up after release from ADAPCP. If a Residential Treatment Facility (RTF) is utilized, the active duty HCP will begin a mandatory nonresidential follow-up treatment program in ADAPCP for the next 12 months.

(a) An aftercare/follow-up care plan will be developed prior to discharge from the RTF and coordinated and signed upon the HCPs return. For active duty personnel, the company commander will prepare the plan. The company commander, the individual and the ADAPCP caseworker will sign the plan.

(b) The MPHP will be provided a copy of the aftercare/follow-up care plan as part of the MPHP monitoring. The individual's company commander will assure a copy of the HCPs aftercare/follow-up care plan is provided to the MPHP Committee.

(c) The plan will include the provision that the HCP has knowledge that they will be followed by the MPHP.

(5) Monitoring During Aftercare/Follow-up Care.

(a) Evidence of compliance will be presented to the MPHP monthly for one year after discharge from an RTF or entry into a treatment. Beyond the first year, MPHP through performance and input from ADAPCP, the company commander, the clinical supervisor and the HCP, will recommend frequency of reporting.

(b) In the event of a relapse, the HCP will be immediately suspended from clinical duties and a full reassessment will be accomplished. This action requires notification of the MPHP.

(c) Tours of duty for impaired HCPs who have been treated at an RTF will be stabilized at least 12 months from the date of release to the RTF.

(6) Reports.

(a) The case manager at ADAPCP will submit monthly written reports to the MPHP for the first 12 months and as contracted thereafter while the HCP is in aftercare/follow-up care.

(b) The immediate supervisor will submit monthly reports (form provided) to the MPHP for the first 12 months and as contracted thereafter regarding the HCP's duty competence while in aftercare/follow-up care.

(c) Individuals monitoring impaired HCPs will notify the supervisor and the MPHP immediately (who will coordinate with ADAPCP) upon any sign of relapse or failure to follow the treatment and/or aftercare plan.

(d) Monthly progress reports will be submitted to the Credentials Committee on any impaired provider who is being followed by the MPHP who is individually privileged.

(e) Reports will be provided to the commander on a regular basis through MPHP Committee minutes. Confidentiality will be maintained through confidential cover sheets.

d. Education. The MPHP will develop and implement an ongoing program of education for staff on the program, impairment and the regulations.

e. Records. QSD, Credentials Management will maintain MPHP records under lock and key. Minutes are written with a log number, identifying providers, and files are maintained by log number. Minutes are collected after each meeting and shredded with the exception of the original set. The documents of the MPHP are considered quality assurance documents and as such are protected under Title 10 United States Code, Section 1102(b). Unauthorized disclosure is strictly prohibited.

The proponent agency for this regulation is Quality Services Division. Users are invited to send comments and suggested improvements to Chief, Quality Services Division.

FOR THE COMMANDER:

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//s//
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GLOSSARY

Section I. Abbreviations

ADAPCP
Army Drug and Alcohol Prevention and Control Program

AR
Army Regulation

CPAC
Civilian Personnel Advisory Center

DCCS
Deputy Commander for Clinical Services

GME
Graduate Medical Education

HCP
Health Care Provider

JAG
Judge Advocate General

MAMC
Madigan Army Medical Center

MFR
Memorandum for Record

MPHP
Madigan Provider Health Program

MTF
Medical Treatment Facility

QSD
Quality Services Division

RTF
Residential Treatment Facility

UCMJ
Uniformed Code of Military Justice

Section II. Terms

Advocacy
To work in the support of, to defend or maintain a cause. In this case, to work in the support of impaired providers, acting as their advocate, within the limitations of the system.

Aftercare/Follow-up Care
The program of activities in the remainder of the one year enrollment following a residential program.

Categorical Privileges
Authorization to provide specific patient care and treatment functions in the organization, within predetermined, documented, defined limits, based on the category of health care personnel. The job description and hospital policy issued to define the categorical privileges. The individual must hold the appropriate and specified training and license and/or registration and/or certification and competence to perform. (Example: Registered Nurse, Respiratory Therapist, Pharmacist, etc.)

Clinical Privileges
Authorization recommended by the Credentials Committee and approved by the Medical Treatment Facility (MTF) Commander, to provide specific patient care and treatment services in the organization, within well defined limits, based on an individual's license, education, training, experience, competence, judgement, and health status.

Health Care Provider (HCP)
For the purposes of this regulation, HCP is defined as any individual who has been granted individual clinical privileges at MAMC, or who has been given direct patient care responsibilities, who is categorically privileged or who can impact patient care directly or indirectly.

Impaired Provider
A HCP assigned or attached to MAMC (active duty, Reserve, National Guard, civilian, contract or volunteer) or who has been granted clinical privileges at MAMC or who has been given direct patient care responsibilities, whether or not privileged, who can not or may not be able to render safe patient care because of a medical or psychiatric problems, including, but not limited to, drug or alcohol abuse or dependence and emotional/behavioral disorders (see AR 40-68, Chapter 7).

Intervention
Used when the behavior that impairs or potentially impairs clinical performance is clearly related to alcohol or other drug abuse or dependence.

Monitoring Plan
A contracted plan between the impaired HCP, the treating physician (if applicable), supervisor and the Madigan Provider Health Program (MPHP) Committee.

Registered
The process of being registered with an officially recognized state or national body that defines, approves, and governs a specified group of healthcare personnel. Requirements for registration for a defined group of healthcare personnel varies for practice. Some registration is optional. (Example: Registered Vascular Technologist (optional), Registered Dietician (required), Registered Respiratory Therapist (requirements vary by state.)